The University of British Columbia
CHANGE FORM –
DENTAL & EXTENDED HEALTH BENEFITS

Print Form | Reset Form

PLEASE PRINT CLEARLY

For Office Use Only:

GROUP NUMBER: 25205

Division: | **Class/Plan:**

(= 7 digit UBC Emloyee ID No.)

Member ID No:

Section A – Member Details (Please use current/former name if indicating name change in Section B)

Member Name: _____ _____ _____
first middle initial last

Birth Date: _____ _____ _____
yyyy mm dd

Effective Date of Change: _____ _____ _____
yyyy mm dd

Section B – New Name or Address Change – Check All Applicable Boxes

☐ **Name Change** _____ _____ _____
(new name) first middle initial last

☐ **Address Change** _____ _____ _____ _____
(new address) mailing city province postal

Section C – Dependents – Add, Change, or Terminate Dependents – Check Applicable Box

☐ **Add** **If adding spouse:** ☐ Date of Marriage _____ _____ _____
yyyy mm dd

☐ Date of Cohabitation _____ _____ _____
yyyy mm dd

☐ **Change** ☐ **Terminate** as per the dependents listed below:

Dependent Names: first	last	**DOB:** yyyy	mm	dd	**Gender:** m / f	**Termination Date** yyyy	mm	dd

Please continue Section C next page…

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Section C – Dependents – Add, Change, or Terminate Dependents - *Continued*

Is your spouse covered for EHB and/or Dental benefits by his/her employer's plan? ☐ yes ☐ no

If **yes,** please indicate spouse's coverage:

Dental: ☐ ee + 1 dep/family ☐ Single

Extended Health Care: ☐ ee + 1 dep/family ☐ Single

Name of Insurance Carrier:

If dependent child is over plan age limit (19, but under 25), and is a full-time student, please indicate name of school:

If dependent child is handicapped, supporting documentation must be provided to Sun Life Assurance Company of Canada in order to approve the continuation of coverage.

Section D - Extended Health Care & Dental Benefits Authorization

I agree to the conditions of the contract between my employer and Sun Life and understand that I and my dependents (if any) must be continuously enrolled under the Provincial Health Plan in order to participate in the extended health care plan.

You must be authorized to disclose information about your spouse and dependents in order to enroll them in the plan. By enrolling in this plan, you authorize the following:

- Sun Life Assurance Company of Canada, its agents and service providers to use and exchange information collected in this form to underwrite, administer benefits and pay claims,
- The University of British Columbia to use the information collected in this form for benefits administration and to make any necessary payroll deductions.

You agree all information in this form is true and complete. A photocopy or an electronic version of this authorization is as valid as the original.

Employee Signature: _____ **Date (m/d/yyyy):** _____

Return form with handwritten signature to:

Payroll
UBC Okanagan campus
ADM 006
1138 Alumni Avenue Kelowna, BC
Canada
V1V 1V7